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At the time Wyoming did not have the treatment capacity to support the enactment of the bill. If the Legislature approves the recommendations contained in this plan, the increased capacity to provide effective treatment would most appropriately be used to achieve this important early intervention as a means of reducing drug related crime.

But, first...

- ⇒ It must be emphasized, however, that the foundation of all of these efforts is the availability of effective treatment. During the study, we frequently encountered troubling situations where teachers, employers, physicians, parents, and others including neighbors knew of the drug use of another but did not know what to do or where to go. One young woman at the Wyoming Girls' School talked about growing up in a home next door to a policeman who failed to act despite loud episodes of domestic violence and obvious signs of drug use. Another told of how her grades plummeted and her physical appearance deteriorated as she began using more and more drugs. She said it must have been apparent to her teachers whom did not intervene.
- ⇒ We believe that good people often fail to intervene because they do not have the tools or because they know that those with the tools use only one...the hammer! A teacher who cares about a student may be reluctant to help if he or she knows that saying something may well

- result in that student's expulsion. A fellow employee who knows of another's drug use will not likely step forward if he or she knows the most likely result will be termination rather than assistance. There is a time to use the hammer. It comes when other tools have been tried and failed.
- ⇒ We want the system to create more tools, tools that will encourage neighbors and others to step forward to help, tools that can be used to force recalcitrant users to get treatment, and tools that will hold the treatment system accountable. And so we turn now to recommendations to develop a comprehensive treatment system that will encourage these things to happen.

Intensive Outpatient Treatment

The writers of this report had anticipated that a study would conclude the most significant gap in the Wyoming treatment delivery system would have been the insufficiency of residential care. That is a major problem. Yet, it is our conclusion that the most damaging deficiency is the lack of intensive outpatient treatment (IOT).

A review of treatment programs readily discloses the paucity of IOT. The table discloses another important, related issue. Of the few programs that exist, there is no standard, no consistency in numbers of contacts hours, integration with other components, use of testing and monitoring, case management, or relapse management.

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The Substance Abuse and Mental Health Services Administration (SAMHSA) publishes a series of technical assistance guides called the *Treatment Improvement Protocol Series* (TIP). One of the publications specifically addresses the vital role of IOT in a comprehensive treatment system.

"The IOT level of care has several clinical and consumer advantages. For instance, the cost of IOT treatment is often less than half the cost of inpatient treatment. In an IOT program, patients can continue to function in already established roles with minimum disruption to work and family life. In fact, work and family life are better stabilized through the support and structure offered by IOT. Access to the world outside the program increases opportunities to practice learned behaviors and new responses such as drug refusal skills, open communication, and stress reduction techniques."213

We recommend that strong IOT programs become a part of the treatment provided by every state-funded substance abuse center. More importantly, these programs should follow the promulgation of treatment standards so that the Legislature may assure they are developed using best practices. It is our conclusion that these programs should be the mainstay of the treatment delivery system. Effective IOT will give parents, the school, employers, the court, including drug court and others an effective program in the community to which people with

problems can receive treatment while remaining in their homes, with their children and on the job while getting clean and sober.

Advantages of IOT Programs Over Inpatient and Typical

Over Inpatient and Typical Outpatient Programs²¹⁴

- Reduced financial costs over inpatient treatment
- Flexible, accessible services
- Increased duration of treatment (better prognosis)
- Higher retention rates than low intensity outpatient care
- Daily real world experiences for clients to apply learned skills
- Increased opportunities to establish community-based support
- Enhanced treatment for relapse
- Greater patient responsibility
- Participation in local selfhelp groups from the outset of treatment
- Enhanced ability to develop long-term supportive relationships with other clients.

Detox

Detoxification is not treatment, but is pre-treatment, and cannot be used or viewed as a substitute for treatment. But it is an important component of a comprehensive treatment system. As such, its relative absence is a major gap in the Wyoming delivery system. Only three of the 20 state-funded substance abuse treatment centers include detox on their menu of services. Another program recently opened in Riverton, is the Fremont County Alcohol Crisis Center. Its early experience demonstrates the importance of providing detox services.

One study defined the role of detox as "procedures for alleviating the short-term symptoms of withdrawal from drug dependence" while including "a period of psychological readjustment designed to prepare the patient to take the next step in ongoing treatment." Detox has three primary purposes:

- ⇒ To provide a safe withdrawal from the drug(s) of dependence and enable the patient to become drug free,
- ⇒ To provide withdrawal that is humane and protects the patient's dignity, and
- ⇒ To prepare the patient for ongoing treatment of his or her AOD (alcohol or other drug) dependence. ²¹⁶

While the comprehensive detox program in Riverton is not likely to be affordable in every community, we should encourage the growth of such centers on a regional basis and require

every substance abuse center to include, even if it is by referral, a detoxification component.

During the 2000 Legislature,
Representatives Luthi, Miller, and
Osborn with Senator Schiffer introduced
HB230 providing for involuntary detox
and treatment commitments. At the time,
the Department felt Wyoming lacked a
treatment delivery system to make the
bill workable. The bill should be
considered once the infrastructure for
treatment is strengthened, with a phase
in allowing the centers six months to a
year to upgrade their programs to
prepare for the implementation of the
proposal. HB230 is further discussed in
the section on coerced treatment.

Continued Education and Training

Another important consequence of inadequate funding is inadequate continued education and training. It is one thing to expect professionals to remain current on the on-going research and studies that impact their work. The reality of being the only or one of a handful of substance abuse therapists in a small Wyoming community is that when your time is under continuous demand to provide help to those in need, there is little time or energy for reading the myriad of journals and doing the other study necessary to remain up to date. Relatively low salaries being paid to Wyoming professionals also have an impact. Several substance abuse center managers told us they feared sending staff to out-of-state trainings because of

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the intense recruiting that takes place at those seminars.

We believe the Substance Abuse Division and the University of Wyoming, working with the community colleges, should be the pivot point for the collection of current research and the dissemination of that information to professionals in the field. By offering continuing education at the regional locations throughout the state, the Division can meet the needs of the centers which include not having therapists away from clients longer than necessary and holding down costs of training. We also believe Wyoming distances require the use of mobile training units as discussed in the next section.

Having studied the practices of the pharmaceutical industry, we believe that by taking a page out of their play book, Wyoming can provide user- friendly continuing education to even the smallest treatment centers. By employing two or three well-informed persons whose job requirements include traveling the state disseminating current information in a user-friendly manner, therapists in even the smallest communities will be kept current on the latest research and therapy techniques. These mobile training teams will provide not only important information but also motivational connections to the Division, other centers and therapists. Therapists will have help with troublesome cases. In this way, the system will create statewide supervision. Importantly, they will also help to assure treatment standards are followed.

We recommend this educational service be provided as a part of the Regional Treatment Teams described below.

Regional Intervention Teams

We encourage the Legislature to authorize the Division to implement a pilot project using Canadian experiments with regional treatment teams. The following is an excerpt from a report provided by DataCorp, one of the experts contracted to review Wyoming's treatment system and make recommendations as a part of the HB83 study. Mobile treatment can be traced back to early American history when doctors routinely provided services within their client's homes.

Additionally, mobile treatment has been used within the mental health field for years. Mobile treatment teams are a multi-disciplinary team of clinicians, caseworkers, outreach workers, psychologists, and psychiatrists who provide home-based services to mentally ill clients (Stein, 1992).

The Canadian Centre for Addiction and Mental Health employs the use of mobile treatment and transportation to increase accessibility of services for rural clients. In rural Canadian communities, accessibility to a full array of health services, including substance abuse treatment is often impeded due to insufficient numbers of health providers, lengthy traveling times, weather, and road conditions. (Virtual Resource for the Addiction Treatment System, Mobile Treatment and Transportation,

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http://sano.camh.net/resource/mobile.ht m). Both mobile treatment services and client transportation programs attempt to respond to these issues by either bringing the treatment to the client, or by providing transportation so the client can get to treatment. Although these forms of mobile treatment are well known in Canada, a less known form of mobile treatment was implemented by the Alberta Alcohol and Drug Abuse Commission (Wiebe & Huebert, 1995). The feature that distinguishes this program from other mobile treatments is the strong emphasis on community involvement. The Alberta mobile treatment team works with the community to help them acknowledge the existence of substance abuse problems and helps them develop commitment to dealing with the problem. They accomplish this by soliciting support from community leaders, and by conducting door-to-door outreach with members of the community. Once the community has been mobilized, the treatment team establishes a short-term residential treatment program for substance abusers and their families. The program is delivered by a team of addiction specialists and whenever possible, community members are trained to assist. The goal is to enroll as many residents as possible, at the same time, into treatment. The intent is to enhance community support, facilitate the development of a supportive network for the addicted, and to encourage other community members to address addiction issues. Because each mobile treatment is tailored to the needs of the community, issues of cultural

appropriateness or relevance are addressed.

Since its introduction in 1984, community mobile treatment has been implemented in approximately 17 Canadian communities located in British Columbia, Saskatchewan, and Alberta. The few evaluations that have been conducted suggest that this approach holds much promise in reducing alcohol and drug-related problems for people residing in rural areas (Wiebe & Huebert, 1995). In addition, Ontario has begun to consider the potential benefits of using this method of service delivery to assist rural and remote clients, as well as other specialized treatment populations (Virtual Resource for the Addiction Treatment System, Mobile Treatment and Transportation, http://sano.camh.net/resource/mobile.ht <u>m</u>).

The very reasons this approach has been successful in Canada causes us to believe it should be tried in Wyoming. Small communities, great distances, the unique, rural nature of the substance abuse problem are a part of our landscape just as it theirs. While a Wyoming program will not exactly mirror the Canadian approach, the basic idea of providing small, remote communities with these resources is both appealing and compelling. Beyond providing services, these mobile units could include prevention resources as well as the continuing education services discussed above. They could provide training to providers, schools, parent groups, law enforcement, businesses, faith-based organizations, and other interested groups. The mobile units

could serve as crisis teams when specific communities have needs. They could do screenings and provide referrals.

Licensing of treatment professionals

One of the consistent complaints we received throughout this study concerned the licensing of treatment professionals. Many providers felt the licensing board created unnecessary barriers to the licensing of qualified professionals, exacerbating the problem of recruiting therapists. Additionally, complaints were raised about amendments to the licensing law enacted during the 2000 Legislative session.

Very clearly, there is a shortage of qualified treatment professionals. The shortage will interfere with the ability of the state to meet the goals of this comprehensive plan unless satisfactory compromises can be reached. The Legislature must find a way to remove unnecessary barriers without allowing unqualified persons to practice.

We believe that one important goal should be to open licensing to recovering persons. Those who have "been there" have a great deal to offer. Their personal experiences with addictions and the treatment system give them important insights. Many recovering persons feel a "calling" to help other addicts. Their gifts need to be used. Frequently though, these folks do not have academic credentials. Telling a "40 something" recovering person that before she can work with other addicted persons that she must go back to college for several

years creates an unnecessary barrier and in most cases will result in the loss of this resource.

We support a joint effort between the Department of Health, the University of Wyoming, the community colleges, and providers to establish a training program that will allow qualified recovering persons to receive the training they need to become contributors. The 2000 amendments to the licensing act created a professional category called "certified addictions practitioner assistant." This training program should recruit and encourage recovering persons to become a part of the state effort. In order to do so however, the Legislature needs to reconsider an amendment to the 2000 law

WS 33-38-106(d)(iv) requires a oneto-one relationship between the certified addictions practitioner assistant and a supervisor. Wyoming professionals universally agree this one-to-one supervision requirement is unnecessarily burdensome and discourages effective use of this new position. We agree with those who have told us the ratio should be no more than three-to-one.

Further, we encourage the board to review decisions it has made with respect to reciprocity requests. While we have not reviewed all such requests, there is a consistent complaint from providers telling of several instances where applicants have been denied licensing on seeming insignificant deficiencies. It is critical this board aid in the effort to recruit and license qualified applicants in order to provide

the human resources required to meet the need.

In a related recommendation, we believe the recovering community offers an enormous resource. Typically those who have found their way through addiction and into recovery feel a "calling" to help others. This state has limited human resources qualified and willing to engage in the tough work of mentoring substance abusers. We would like to see recovering addicts and exoffender graduates of quality long-term treatment programs recruited to join the staffs of treatment facilities and programs. If we combine their real world experience and commitment with an effective training program, they could bring to the treatment effort valuable gifts to augment available resources.

Grants Assistance

During the course of the study we became aware of innumerable funding opportunities for substance abuse prevention and treatment programs. In addition to federal grants, there are many private foundations that are placing significant resources into community efforts to address the problem.

We have found that in many cases, school districts or other local government and private entities are illequipped to learn about these opportunities and even less able to write credible grant applications. Grant writing is a science and ill-prepared grants seldom result in funding.

We believe the Legislature should fund a pilot project by allocating funds allowing the Department of Health to contract with a private entity that has significant expertise, experience, and success in writing grant proposals. The contract would provide a base payment with incentives. Through priorities established by the Department, the contractor would be available to agencies of state government, units of local government, drug courts, and other public and private sector organizations to provide technical assistance in identifying grant opportunities and writing grant applications.

This program should be funded for two years and then its usefulness evaluated.

Conclusion

"What I learned...convinced me that in coerced treatment rests the elusive secret to effective rehab. That secret, however, lies not only in coercing addicts into programs, but in coercing the programs to do rehab right!" 217

"Accountability" is the key to understanding this plan. As policymakers consider the recommendations, we hope they will keep standards of accountability at the fore. Combining accountability for substance abusers with measures assuring accountability of treatment providers will produce an effective system. In the final analysis, we must work together to create a system through which the people of Wyoming get their money's worth. Establishing a comprehensive system will be expensive. We do not want the

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Legislature to simply "throw money" at the problem, yet it will take significant dollars to improve the current system to achieve the results. We recommend the Legislature enact accountability provisions so that the taxpayers may be assured their investment will pay off.

Among the accountability reforms we seek are as follows:

- ⇒ Authorize the Departments of Corrections, Education, Family Services, and the Department of Health to work together to jointly promulgate strong research-based, Wyoming specific treatment standards.
- ⇒ Authorize these departments to jointly promulgate rules designating researchbased instruments to be used for intake, assessment, diagnosis, monitoring, testing, and determining appropriate levels of services for clients.

- ⇒ Authorize these departments to jointly promulgate rules for using data to establish target or priority populations for services.
- ⇒ Authorize these departments to jointly promulgate rules for data collection and outcome evaluations.
- ⇒ Require the above rules be promulgated no later than September 1, 2002.
- ⇒ Require these departments to report annually on the outcomes achieved by specific programs and other matters indicating whether systemic goals are being met.
- ⇒ Require that the Department of Health may not contract with and no court may refer persons to programs that are not certified as complying with the rules.



Helping Kids! Helping Families! Helping Communities!

The Wyoming Legislature is encouraged to support initiatives that strengthen Wyoming families by making Wyoming kids and their families a priority when tough choices have to be made. Using research-based programs, the Legislature is asked to provide prevention and early intervention programs designed to break the cycle of substance abuse.

The image, the reality...and the vision!

The image of the West has always been an important part of who we are. We often speak of Wyoming as being "what America was." We talk about our beloved state as being "like no place on earth. To simply say "Wyoming" creates images of great mountains, vast prairies, roaming wildlife and clear, flowing streams. The image includes small towns with strong values, connected one community to another by caring people. A former Governor was fond of saying that Wyoming is 'one small town with very long streets.' How often we say, 'Wyoming is a great place to raise a family.' The people of Wyoming have a self-image as well. It is one of rugged individualism, ingenuity, confidence, and courage. We see ourselves as independent and strong, able to meet the challenges of

life in a way uniquely formed by our rural experience.

It is that image that has always beckoned people to come. They came and they continue to come in order to better themselves, if not materially, then spiritually. They come even today relying on that image to give them and their children a quality of life they cannot find anywhere else.

But...does the image square with the reality?²¹⁸

For many of our fellow citizens, the promise of life in Wyoming has been fulfilled. But because of the increasingly widespread abuse of alcohol, meth, and other drugs, there is a growing number for whom the promise has given way to the reality of addiction, domestic violence, child neglect and abuse, educational and occupational failure, and hopelessness. This is a reality that has fallen tragically and disproportionately on Wyoming's young people and their families.

The statistics tell one story...

Statistics are able to convey important information. They can also tell stories only if the reader is able to imagine the reality portrayed by them. As you read these statistics, imagine. Imagine how they translate into the daily life of teachers, parents, young people, and families. Imagine what these numbers mean in neighborhoods and communities.

For example, when you read statistical information that informs you that a pound of meth, cut for sale in your community has a street value of approximately \$40,000, you may find that to be quite interesting information. But it becomes compelling information if you are able to imagine what havoc that pound of meth creates in your community.

First, there is the obvious impact. Somebody uses the drug. Its use begins or furthers a deadly addiction. There is a community-wide impact on the families involved, the school system, employers, and others.

In the process of bringing that pound of meth into your community, the dealer takes out \$40,000. From where does that large amount of money come? Much of it comes from the proceeds of crimes like check fraud, burglaries, and robberies. Some of it comes from money stolen from parents and grandparents, crimes that most often go unreported, dollars that were needed to support children, grandchildren, and families. The stories behind the stats paint a picture of havoc wreaked by drugs.

Last year, the Division of Criminal Investigation alone seized 3528 grams of

cocaine with a street value of over \$388,000. The 270,899 grams of marijuana seized would have sold for as much as \$722,000! Nearly 8000 grams of meth were seized in 2000. It is valued at \$800,000. PLEASE note these numbers do not reflect the true drug activity on the streets of our towns. These numbers reflect only the amounts and values of drugs actually seized by one law enforcement agency. There are likely many times more than this being passed through to our kids and others.

And indeed, our children are the most vulnerable. According to studies completed recently, Wyoming young people are at or near the top in the nation in too many categories of substance abuse. They are first in current cocaine use and use of that drug before the age of 13. Each month, one of 10 of our 8th graders reports she gets drunk. The number rises to one in three by the time they are in high school. ²²⁰

Most alarming is the fact that over 40% of Wyoming children surveyed in grades 10-12 meet the DSM-IV definition of a current alcohol and/or drug abuser and the substance use of one in ten is so high as to classify them as dependent.²²¹

Over the years, Wyoming has had a higher than average "low birth weight rate." Low birth weight is frequently an accurate predictor of health problems, substance abuse, and delinquent behavior. It is often caused by the use of tobacco, alcohol and/or other drugs by the mother while pregnant. Two-thirds of Wyoming women of childbearing age, surveyed in health clinics under one study, were shown

to be using tobacco, alcohol, and/or illegal drugs. Forty percent of them were in fact pregnant at the time and 10% admitted to using all three.²²²

...the children tell another

The statistics may tell the story but not near so convincingly as the young people and their parents whose lives have been altered by substance abuse. For example, we sat with a group of young men at the Intensive Treatment Unit at Rawlins. There we heard stories of how they began using alcohol and other drugs as young as 5 or 6 years of age. "My grandfather said he wanted to teach me to be a man," said one inmate. He was 5 years old when he first got drunk...with his grandfather.

The Legislature should deal with the fact that this grandfather was not breaking any law by providing his 5 year-old grandson with alcohol. Under Wyoming law, a member of the immediate family may legally provide alcohol to a minor regardless of age. Shamefully, neither was this 5 year-old in violation of the law so long as he was "in the presence of his parent or legal guardian." W.S. 12-6-101.

A 16 year-old girl told of how she grew up in a home with parents who were "big drug dealers and everyone in town knew it." Once a star athlete and good student, she succumbed to family "norms" and became an addict, being jailed 70 times before finally being sent to the

Wyoming Girl's School where she received the treatment she needed. "Why," she asked us, "Why didn't someone come and take me out of that house?"

Lest you operate on the myth that this happens only in broken homes or with "bad parents" listen to another youngster. The 16 year old boy, told us that he grew up in a "good home" with an intact family, "good parent who set clear boundaries, talked about the danger of drugs." Yet he began having academic and social problems by the 6th grade and was using marijuana daily by the 8th grade, later running away, expelled from school, he ended up at the Boy's School.

Many times the community is deaf to the cries of troubled kids. JoAnne's (not her real name) mother used heroin. Her earliest childhood memories are of mom...shooting up. When JoAnne was in the 1st grade, she found some of her mother's drugs and took them to school. If it was a clear cry for help, it went unanswered. Mom was arrested but the little girl was sent to live with her alcoholic father in a home without adequate supervision. By the 9th grade she was drug and alcohol dependent, using marijuana, cocaine, PCP, crank (meth), and huffing. Placed on probation, she continued to use even though she was tested regularly. Tested 90 times, she failed only 7 of the tests despite continuous drug use. One of the people who taught her how to beat the UA's, she says, was her caseworker.

If you have no contact with families that have experienced substance abuse and are willing to talk about it, it is easy to

reach erroneous conclusions. On the other hand, when you sit with young people and hear their stories, it quickly becomes clear that the issue is so much more complex than it would be if it were simply a matter of someone making "a bad choice." Genetics play a role, a major role, and one that defies even the best parenting.

For kids who grow up in homes where substance abuse is a part of their reality, choices have been made for them. It is easy for spectators to argue that parents should be more responsible. Clearly they should. But some are not. Some are giving it their best shot and that may not be enough given limited parenting skills that are passed along from one dysfunctional generation to another. Read this actual essay written by a little Wyoming school girl.

Figure 43: A Little Girl's Story

amly I was in school it was three days we got out for the summer my man pold us out of school that day we did not know were we where going and our mom tould us that where mouving we went to our house and stuf in boxes and we loded them on a truck and left. We made a rong Were and we mouved our stuf in to a Lontree: that was were my man met Rick Ray. Rick mouved in with my mom. I not like that but I had to live my life grow longer school stored and I was I'm still in school. one of my freind are nice. My dad moved to floret. I miss my dad from this day on. Noveber my bothday is coming mom said if I don't straten my atutad up I want get anything for my both day little gril my dad rasd him in a sem i it was Love it. My dad came to get us us to Lander to veset MY Grawn I had a good time we Left and my dad drop us of I started crying Iwas brack a part and scard my hol Life would he rot us a not savena hi and he Loved us cry for two days I did not steep our drenck our tatk I was scard was over I was tird of fiting

These sorts of stories may not be commonplace in the social circles in which most of us spend our lives.

However, if you dwell *even for a brief moment* where teachers, social workers, public health nurses, probation officers, judges, and substance abuse therapists dwell, you will find these Wyoming stories to be troublingly commonplace.

These stories describe the reality of life for a growing number of Wyoming children, families, and communities.

This plan is the basis for a renewed commitment to dramatically and quickly change their reality.

The Department of Family Services

The central player in children and family services is obviously the Department of Family Services. The Department provides services for youth through three general program areas; child protective services, youth and family services, and juvenile probation. A majority of the young people for whom services are provided enter the system with significant substance abuse issues, sometimes it is their abuse of substances, at times the abuse of drugs or alcohol by parents or other care givers, often both. Frequently this problem co-occurs with emotional, psychological, educational, and other behavioral issues.

Juvenile court involvement is a common characteristic, either through a consent decree or adjudication as a status

offender (Child in Need of Supervision or CHINS) or delinquent.

Services are provided in the home, or in community programs or court directed placement. Home and community services provided for young people with substance abuse problems are most often provided in the context of probation supervision, therapeutic/specialized foster care, and group home involvement. Out of community placement services are provided in a residential treatment setting or the Wyoming Boys' or Girls' Schools.

According to a state budget analysis by the National Center on Addiction and Substance Abuse (CASA), total state expenditure on juvenile justice matters in FY98 exceeded 16 million dollars. CASA estimates 66.7% of that was spent on substance abuse involved offenders.

Table 7: Placement of and Expenditures for Wyoming Juveniles for 2000-2001

PLACEMENT AND EXPENDITURES FY 00

| | # YOUTH | |
|-------------------|---------|---------------|
| | | EXPENDITURES |
| RESIDENTIAL TRTMT | 489 | \$ 10,884,166 |
| GROUP HOME | 379 | \$ 2,578,546 |
| THERAPEUTIC FC | 131 | \$ 383,763 |
| SPECIALIZED FC | 175 | \$ 648,175 |
| WBS | 204 | |
| WGS | 104 | |

FY 01

| | # YOUTH | |
|-------------------|---------|---------------|
| | | EXPENDITURES |
| RESIDENTIAL TRTMT | 564 | \$ 12,160,480 |
| GROUP HOME | 435 | \$ 2,796,354 |
| THERAPEUTIC FC | 128 | \$ 378,748 |
| SPECIALIZED FC | 182 | \$ 829,992 |
| WBS | 199 | |
| WGS | 106 | |

Dealing with the substance abuse problem

According to DFS, recent data from residential care providers reveal that as many as 76% of the children entering the system have significant substance abuse problems. Virtually 100% of the boys entering the Boys' School and 83% of the girls going to Sheridan have substance abuse problems. The statistics are mind-boggling. The average age of kids entering either the Boys' or Girl's School is about 16. The boys have already experienced 7 "out of home" placements and the girls 5.

Only about one-half of the boys and less than a quarter of the girls report a positive experience in school. Nearly one in four were expelled from school because of drug/alcohol use.

Policymakers need to understand how young they are when they begin to drink or use. Average age of girls' first use of tobacco is 10, while boys, on average, start smoking before they are 9. This is critical information. The studies are quite clear that it is frequently this early use of tobacco that leads to the use of harder drugs and alcohol as well as delinquent behavior. One study compared 7th grade

smokers, experimenters, and non-smokers at both 7th and 12th grades. It found that when compared with the non-smokers, early smokers were at least 3 times more likely to use marijuana and harder drugs, sell drugs, have multiple drug problems, drop out of school, and experience early pregnancy and parenthood.²²³

Does this mean that everyone who smokes cigarettes becomes a drug addict? Of course not. But it does mean that when you start so young, while the brain is still forming and growing, there is a seriously heightened chance that the child will abuse harder drugs.

The predictive factor of early tobacco use found in the studies, holds true with these Wyoming kids. Among them hard drug use began at 9 years of age among the boys and under 12 for the girls. The problem appears to be worsening. In a 1999 survey of the boys, 17% said they could not get through a week without drugs. In 2000, that number had jumped to 43%. In the 1999 survey, only 29% admitted they had engaged in criminal activity in order to obtain drugs. In the 2000 survey, nearly half made that same admission.

Despite this high rate of alcohol and other drug use and despite the fact that these kids had been in the juvenile system an average of about 3 years each before going to the Boys' School, only one in three has received prior treatment.

In addition to the children placed in residential care, there are about 1000 each year in the Department's probation supervision program. At least 80% of them have substance abuse problems.

Oftentimes the caseload for regular probation officers is burdensome, averaging 50 youth per officer. A caseload this high precludes the kind of intensive supervision and case management required to be successful for many of these youthful offenders. To meet the challenge, DFS has begun an Intensive Supervision Probation program, modeled after the adult ISP. Currently the program operates only in Laramie and Natrona counties and on a limited basis. There are two ISP agents in each county with caseloads averaging 15 youth.

As with the adult counterpart, this program employs drug testing, intense monitoring and supervision, a range of immediate sanctions, and partners with local services to meet the needs of the kids in the program. One of the most common comments received from judges, prosecuting attorneys and other people working in the juvenile system was that this program works. It should be expanded.

Findings

A significant amount of time in the course of this study focused on the juvenile population. We are persuaded that while the state must address the needs of adult offenders and substance abusers, the real opportunity to break the cycle lies with the development and implementation of early intervention programs targeting young, at-risk children. The following is a summary of the study's findings:

⇒ Substance abuse among Wyoming's youth is at a crisis level.

- ⇒ The perception of the ready availability of alcohol and other drugs itself leads to higher use rates among young people.
- ⇒ A permissive cultural attitude in our state about the early use of tobacco and alcohol must be confronted.
- ⇒ A successful effort to reduce risky youth behavior must take a lifespan approach with an understanding that many of the problems kids have begin when they are in the womb and/or by the age of three years.
- ⇒ The early use of tobacco products poses a serious problem.
- ⇒ Underage drinking results from easy access to alcohol and poses a serious problem.
- ⇒ Untreated substance abusers become parents and, left untreated, their troublesome values and lifestyles are passed along to the next generation.
- ⇒ There are insufficient adolescent treatment programs in Wyoming at all levels including traditional outpatient, IOT, residential, and detox.
- ⇒ Existing treatment programs including the residential programs are attempting to meet the need but are under funded for that purpose, do not have standards under which they deliver the treatment, and offer inconsistent treatment.
- ⇒ There is a lack of effective case management, transition programming, and aftercare for adolescents.

- ⇒ Too many young people are being criminalized and/or jailed and although statutory procedures exist for the expunging of juvenile records, the process is unnecessarily complicated.
- ⇒ A multiplicity of courts addressing youthful offenders results in an inability for the system to know what it needs to know about each child.
- ⇒ Consistent assessments of youth and their families are necessary to determine the needs. Currently assessments are not consistent and often families are not included.
- ⇒ Courts are not using the statutory authority they have to coerce parents into treatment along with the children who come into the system.

Recommendations

The recommendations that follow are intended to overlay a commitment to enhance the community treatment structure as recommended elsewhere in this report. It is expected those improvements will permit early intervention in the substance abuse and related problems of youth and families. For example, the Department of Family Services has identified one of the key gaps in youth services to be the lack of detox facilities. When an adolescent is arrested, the responsibility for detox usually falls on the jail, the community crisis care provider, or the family, none of whom have the expertise to handle that crisis safely. This is one of several significant gaps that should be addressed in the

proposals to enhance community treatment delivery.

Another important impact of that part of the plan will be the availability of intensive outpatient treatment. Filling this critical gap will open important, effective treatment doors for these kids and their families, giving courts and DFS a major new tool to succeed in their work.

Treatment standards

One of the consistent complaints we heard throughout the course of this study was that there are no standards for treatment. The result is an inconsistency in approaches from one provider to another and from one facility to another. The services provided to families and youth will greatly benefit from the establishment of high treatment standards. It is necessary that treatment standards include specific requirements for adolescent treatment. Community-based programs have been found to be very effective early interventions for young people if they are designed and implemented correctly.²²⁴ These programs must include strategies specific to youth in order to engage them until completion.

Legislators who fund these programs, judges who place juveniles in them, and the families they serve need to know that the program meets research-based standards and that the outcomes are being continually evaluated to make certain the programs deliver. There is far too much at stake to do anything less.

The standards should include protocols for drug testing. The young people with

whom we spoke talked candidly about the failures in the current testing system.

Testing is a key element of treatment and the integrity of the tests must be protected by uniform standards that change to meet available technology.

It is also critical that the high standards adopted be applied equally to publicly funded programs as well as the private programs to which courts frequently refer juveniles. As recommended elsewhere in this report, the Departments of Family Services, Education, Corrections, and Health should jointly set the standards.

Review of existing treatment programs

Substance abuse treatment is provided currently at the Boys' School and the Girls' School as well as other residential treatment facilities in Wyoming at which children are placed such as Cathedral Home and St. Joseph's. The treatment, however, is inconsistent from one institution to another. This study has not adequately reviewed the programs to reach solid conclusions about the effectiveness but we do have concerns. For example, the average length of stay at the Boys' School, for some with substance abuse problems is about two months.²²⁵ This is the result of the fact that the Boys' School takes in an average of about twice the number taken in each year by the Girls' School. The average length of stay for all boys is about 5.5 months. The girls, on the other hand, remain at Sheridan for an average of ninemonths. That is about the recommended length of stay for effective residential treatment.²²⁶

As important as these two facilities are and given the extraordinarily high rate of substance abuse among the kids placed there, we believe it is imperative that the Legislature fund a performance-based assessment of these programs as well as the other programs to which juveniles are referred. The goal should be not to criticize anyone. We are persuaded that those who administer these programs are doing the best they can with the resources they have. But there has been significant, recent research on what makes a juvenile treatment programs effective. It is time for Wyoming to assess these programs and adopt research-based recommendations to improve the treatment provided. These programs provide a critical opportunity for early intervention that can save the young person years of trouble and save the taxpayers millions of dollars.

It is recommended that independent adolescent treatment experts conduct the review, using research-based, up-to-date criteria. The review should be jointly overseen by the Department of Health, the Substance Abuse Division, and DFS. Recommendations should be implemented as soon as possible.

Intensive Supervised Probation

There is general agreement that the DFS initiative with intensive supervised probation has been successful. We recommend a major expansion of the program. Though it is expensive, these expenditures should reasonably be expected to avert millions of dollars in other expenditures for the juveniles who

are placed in ISP. It also saves families...and lives.

ISP permits an agent to concentrate time and resources on a smaller, more manageable caseload. Their caseload of about 15 compares with the normal probation officer's 50. The smaller caseload is oftentimes the difference between early success in a kid's life and continuing encounters with drugs and the law. ISP agents intensely supervise their charges, visiting them at school, work, and in the home. The program usually lasts eight months and uses three levels of restrictions and a range of sanctions to hold youthful offenders accountable. Many of the young people to whom we spoke told us this program had been the difference in staying clean. They knew the ISP agent would be checking on them and testing them. They also found this to be someone to whom they could turn when they needed help.

Importantly, an expanded ISP program would give the courts and communities an effective alternative to out-of-home placements and incarceration while permitting the treatment to take place in the context of the home. Kids can stay at home and in school. ISP promotes accountability in a way that gives greater assurance of effective treatment while protecting public safety.

Just as with adult ISP, these officers will use a system of graduated sanctions to hold their wards accountable. Graduated sanctions provide the means to immediately address behavior, good and bad.

"Graduated sanctions hold juveniles accountable for their actions and, at the same time, reward them for positive progress toward rehabilitation. *** Based on an individual's progress, sanctions and therapeutic interventions can be made more or less intense. If the offender lapses into alcohol or drug use and/or delinquent behavior at any point in the treatment process, graduated sanctions involving placing the juvenile in a higher security, more

intense therapeutic environment are applied."²²⁷

Real, long-term change is promoted by providing intensive services for substance abuse, case management, mental health, life skills, cognitive behavior, education/vocational training, and employment skills.

ISP can serve as an effective alternative to residential placement and also as the means of transitioning young people from institutions to the community.

...actual text of letter from a Wyoming young person

"What I want for probation that I think will help

- one-on-one counseling
- random UA's
- (12 step) meetings often as can
- getting strict probation
- not telling me when I am going to get a UA or when my probation will end
- getting set up with things (activities) to keep me busy
- a job that will keep me at work on a late shift on weekends
- not setting me up with groups that involve youngsters that get court ordered there because I will not talk because they may go out and talk about what I say to their friends
- calling my house to check on me and to see if I make it in when I am supposed to and am doing what I am told."

Families must be held accountable

When a young person is identified as having a substance abuse problem, most often successful treatment requires family

participation. Some families are quite willing to be a part of the process. However, we more frequently heard of families that were less than cooperative. In some cases, one or both parents have their own substance abuse problem. A private services provider told of parents who

refused to remove the alcohol from their homes even though the refusal meant their child could not then come home for a weekend visit.

In other cases, the child has so disrupted the family, that parents are ready to simply turn him or her over to "the system" to be taken care of. Regardless of the reason, it is problematic to try to treat a child without involving the family.

We believe families must be held accountable for the recovery of their child. Expecting "the system" to make their child well without the participation, financially and personally, of the parents is unfair and ineffective.

It is hoped that the enhancement of the community treatment system will open more doors to families that voluntarily seek treatment for a child. However, when the child comes into the system, the participation of parents should no longer be voluntary and their unwillingness to participate should not be tolerated. Although the courts have sufficient statutory authority to require parents to undergo treatment with their child and to be financially responsible, it appears that does not happen regularly. Courts must be urged to make these expectations mandatory unless the participation of a parent presents a danger to the child.

Examples of statutory authority

WS 14-6-203. [T]he court has jurisdiction to...order any party to the proceedings to perform any acts, duties, and responsibilities the court deems necessary...to refrain from any act or conduct the court deems detrimental to the best interest and welfare of the minor....

WS 14-6-247. [T]he juvenile court may...order the child, his parents, or the guardian, to undergo evaluation and indicated treatment or another program designed to address problems which contributed to the adjudication...order the child's...parents to participate in the child's treatment...require the child's parents or guardian to attend parenting classes or other appropriate education or treatment at their own expense.

WS 14-6-415. The court shall insure the presence at any hearing of the parents, guardian or custodian of any child subject to the proceedings under this act.

WS 14-6-229. The court...shall order the parents or other legally obligated person to pay a reasonable sum for the support and treatment of the child....

When a child enters the system, he or she should be fully assessed. So should his or her parents. *The statutes dealing with* examinations appear to apply only to the child. WS 14-6-219 (Juvenile Justice Act) and 14-6-419 (CHINS) provide for court ordered examinations of the child These statutes should be amended to include the parents or guardians where it is suspected their own use of alcohol or drugs is a factor. If the parent has a substance abuse problem, it must be treated along with that of the child. Even if the parent is not abusing substances, addiction is a disease that affects the family and parents can be helpful to their child by learning something about the nature of addiction and how to avoid enabling their child.

Frequently there are family dynamics that contribute to the child's drug use that need to be addressed in treatment

It is recommended that the statutes be amended to mandate that the court may not order out-of home placements by the court until after other alternatives prove unsuccessful. With the enhancement of the community treatment system recommended in this report, there will be sufficient outpatient services available to reasonably accommodate the needs of many families while permitting the child to remain in the home and in his school. In the event these services are inadequate, the court should then be able to impose out-of-home placements in the community. If the court finds on the basis of the evidence

that community placements are inadequate, it may order an out-of-community placement.

This change is intended to emphasize the need to treat substance abuse as a family problem, to hold parents accountable, and to enhance community treatment systems while holding down costs.

We recommend statutory changes that mandate family assessments and participation. Further we recommend the Child Protective Services Act and the Child Protection Act be amended to define "abuse" and "neglect" to include allowing illegal drugs to be present in the home of a minor and permitting the minor to use drugs or alcohol or exposing the child to the use of illegal drugs by others.

Juvenile Offender Accountability

As with adult offenders, juveniles must be held accountable for their conduct. Holding children accountable may be the most effective early prevention technique. However, courts need to recognize that the earlier a child first goes to jail, the more likely she or he is to have repeated detentions and even go to prison as an adult. Accordingly, we need to think harder about which juvenile offenses justify jail time and which demand alternatives

As we have recommended with adult offenders, we also recommend that the courts be required to look at whether there is an effective treatment alternative before placing a child in detention.

In a Nutshell...

- All juveniles who are convicted of or plead guilty to alcohol or drug related charges or are convicted of or plead guilty to a felony will receive, as a part of a presentence report, a substance abuse assessment.
- Qualified offenders will be given an opportunity for treatment.
- "Qualified offenders" are persons whose substance abuse assessment demonstrates they have a dependency on drugs and/ or alcohol.
- Those juveniles who pose an unreasonable risk to public safety are not "qualified offenders" for purposes of this act.
- Qualified offenders must be given a suspended sentence requiring them to complete a treatment program provided there is an adequate treatment program available.
- "Adequate treatment program" is a community-based or other non-prison/jail treatment program certified by the Wyoming Department of Health for purposes of treating the adolescent, criminal justice population that includes protections that can be reasonably relied upon to protect the public safety and hold the offender accountable.
- A qualified offender may be sentenced to jail or, where permitted under law, prison only if the court concludes, on the basis of the evidence that no adequate treatment alternative exists, if he commits a felony while in the program or engages in conduct posing an unreasonable risk to public safety. In the absence of the commission of a new crime, probation under this section shall not be revoked.

During the course of our study, there were many who raised concerns about criminalizing young people. Some courts have routinely sentenced young people to as much as 45 days in jail for possession of marijuana. Under federal law there are long-term consequences tied to some drug convictions including the loss of some educational benefits. Additionally, there is a problem resulting from the multiplicity of courts involved with, at times, the same child.

Under the Juvenile Justice Act, the juvenile court shares jurisdiction in certain cases including minor-in-possession offenses. Accordingly, the same or similar conduct may be treated in the juvenile court at one time and in the county or circuit court on another. The result is inconsistent disposition and a lack of communication between courts.

While we firmly believe drug law offenders must be held accountable. under the reforms of the treatment system recommended herein, the courts will have the necessary tools to intervene early, make a difference in the lives of children, and hold them accountable. We have found teachers, parents, and others who are afraid to intervene now because the potential penalty and impact on the child's life are so potentially onerous. The goal need not be to simply punish but must be, as well, to educate, treat, and hold these young offenders accountable in a way that does no longterm damage to their lives.

The proposed act will make treatment the preference. We would encourage the legislature to enact

additional provisions making the first offense one that results in a pre-plea diversion, i.e. on the first offense, the youthful offender who is qualified for the treatment alternative would be given that opportunity prior to the entry of a guilt finding. The charge would then be dismissed upon successful graduation from treatment. Failure to complete the program would result in the entry of the guilty plea and sentencing would proceed accordingly.

Along the same lines, we urge the Legislature to review the expunging statute in an effort to make it more meaningful. W.S. 14-6-440 currently allows for the expunging of juvenile court records once a child reaches the age of majority. The law, though, requires the person to petition the court. The expunging should be automatic. The statute should provide that in the absence of the commission of a felony since adjudication, all juvenile misdemeanor offenses are deemed expunged without petition or further order of the court. Under the current law, only those young people who are both aware of the existence of the procedure and able to use it, are able to take advantage. The formal filing of a petition serves no purpose but to penalize the unknowing.

Competitive Purchase of Treatment Services by DFS

While the recommendations in this report are, in significant part, intended to strengthen Wyoming's community mental health and substance abuse centers, we have also concluded that

creating a competitive system is a valid goal in improving treatment.

While we are asking the Legislature to enhance the ability of the community centers to provide effective treatment, we recognize there are other public and private providers who should be given an opportunity to compete. It is urged that significant funding be included in the DFS budget for the direct purchase of services under a Request for Proposal process. Contracts should be entered directly between the Department and the provider giving the Department significant control over the quality of the services and the accountability of both the provider and the offender.

At the same time, the Department of Health should certify additional providers to receive Medicaid payments for treatment services. No one group of providers is able to fully meet the need. Therefore, we believe creating "preferred provider" status for one group is unwarranted. So long as the provider meets the treatment standards established through the recommendations contained herein and is certified by the Department of Health, the provider should be able to receive Medicaid payments.

TANF

The following paragraphs are taken directly from a document issued by the US Department of Health and Human Services, Administration for Children and Families, Office of Family Assistance. The booklet is entitled "Helping families Achieve Self-

Sufficiency: A Guide on Funding Services for Children and Families Through the TANF Program." It is designed to simplify a rather complex program.

"States decide the services or benefits that are to be provided using their Federal and State funds. A State must use all of its Federal TANF and State MOE (maintenance of effort) funds to meet one of the four purposes articulated in the Federal TANF statute or, in the case of the Federal TANF funds, to continue providing services and benefits that it was authorized to provide under its former (statute) which covered Aid to Families With Dependent Children, Emergency Assistance, Job Opportunities and Basic Skills Training and Supportive Services. In brief, the four purposes are:

- 1. Provide assistance to needy families,
- 2. End the dependence of needy parents by promoting job preparation, work, and marriage,
- 3. Prevent and reduce out-of-wedlock pregnancies; and
- 4. Encourage the formation and maintenance of two-parent families.

It is recommended that priority be given to the use of TANF funds that furthers the goals set forth in this report. These funds provide significant opportunities to support prevention as well as treatment programs for a population that should be targeted.

Medicaid and Kidcare

In order to provide additional treatment options to priority populations, we encourage the legislature to expand eligibility for the Children's health Insurance Program and to allow additional providers to become eligible for Medicaid payments.

Today Wyoming has the most restrictive income qualification in the nation. While 39 states allow families at or above 200% of the federal poverty line to be eligible, Wyoming precludes eligibility unless the family income is below 133%. The standard not only denies health insurance to many of Wyoming's working families, it also limits the availability of substance abuse and other mental health services to these families, many of whom are at risk.

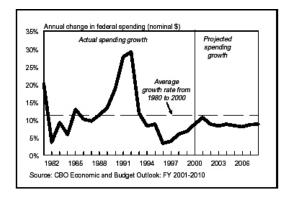
These options would mean the federal government would make available most of the new dollars needed in this part of the system.

Would expanding Medicaid increase costs for the state? Several items of data suggest that Medicaid and expansion of services to children would have modest impact on costs:

⇒ The Congressional Budget Office (CBO) is projecting increases in Medicaid spending at annual rates of 8% to 9% over the next couple of years. This is below the average annual rate of increase of 11% between 1980 and 2000. The CBO study indicates that the increase is attributable to increased use of health services and health care inflation. The authors conclude that Medicaid

has been moderately more successful than the private sector in holding down health care costs per enrollee in 1999 and 2000 with continued expectations into 2003—even though Medicaid pays far more for substance abuse and mental health related claims (which the private sector does not).

Figure 44: Projected Federal Medicaid Expenditures by Congressional Budget Office



- ⇒ Federal Medicaid costs have been rising faster than state costs. Data from the National Association of State Budget Officers indicate that while federal Medicaid expenditures rose 7.3 percent during state fiscal year 1999, Medicaid expenditures financed from state general funds grew 5.6 percent.
- ⇒ According to a report by the Center on Budget Policy and Priorities (April, 2001), the key factors underlying the projected growth in Medicaid expenditures are increased utilization of health services and health care inflation, including increases in the cost of prescription drugs. Analyses of the CBO estimates indicate that nearly threefourths of the projected increase in

federal Medicaid expenditures over the next five years will be attributable to these factors. Interestingly, analyses of the most significant increases in prescription drugs are for psychotropic drugs largely for many of the co-morbid mental illnesses that may be prevented over time by the interventions recommended in this plan.

- ⇒ Care for disabled and elderly beneficiaries (not children) is expected to have a much more powerful effect on Medicaid expenditure growth, both because those beneficiaries are considerably more expensive to serve on average and because the number of disabled beneficiaries is expected to grow faster than the number of other types of beneficiaries. Nearly threequarters (75%) of the projected increase in federal Medicaid spending from 2001 to 2006 is related to the provision of health care to disabled and elderly beneficiaries. CBO estimates show that more than half of the total increase in Medicaid expenditures in these years will result from higher average health care costs per enrollee for the current number of disabled and elderly beneficiaries, while about one-fifth of the overall increase in Medicaid costs will be due to the cost of serving additional elderly and disabled beneficiaries
- ⇒ Analyses of the new CBO projections, however, indicate that increased enrollment of children is

not a significant factor behind the projected increases in Medicaid expenditures nationally, nor will enrollment of more parents be a large factor. Specifically, the new estimates anticipate that six percent of the increase in federal Medicaid expenditures during the current year will be attributable to the enrollment of more children (and an additional two percent due to increases in the number of adults enrolled.